Exhibit A7

(Page 3 of 4)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

UNITED HEALTHCAREMETRAHEALTH
PO BOX 30555
SALT LAKE CITY UT 84130

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse [X] / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY / STATE

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY / STATE

ZIP CODE / TELEPHONE (Include Area Code)

ZIP CODE / TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 304000

a. OTHER INSURED'S POLICY OR GROUP NUMBER: W168262787

a. EMPLOYMENT? (Current or Previous) YES / NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH — SEX M / F [X]

b. AUTO ACCIDENT? YES / NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES / NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED HEALTHCAREMETRAHEALTH

d. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA US HEALTHCARE

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] / NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE — DATE 03/02/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 12 02 2010 ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 12 02 2010

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM / TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JANIS CORNWELL MD

17a.

17b. NPI 1023006871

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM / TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO [X] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 626 2

2.

3.

4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1	12 02 10	12 02 10	11		00952	AA	1	MINUTES: 98 3600 00	16		NPI	1881802932
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

EOB ATTACHED

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 263189406 — SSN / EIN [X]

26. PATIENT'S ACCOUNT NO.: PAGDE000 5998

27. ACCEPT ASSIGNMENT? YES [X] / NO

28. TOTAL CHARGE $ 3600.00

29. AMOUNT PAID $

30. BALANCE DUE $ 3600.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
CHRISTOPHER EKSTAM DO

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION
MATLOCK OBGYN ASSOC PA
515 W MAYFIELD 200
ARLINGTON TX 76014
a. 1306847140 b.

33. BILLING PROVIDER INFO & PH # (903) 4508704
PARAGON AMBULATORY PHYS SERV
11700 PRESTON RD STE 660506
DALLAS TX 75230
a. 1083861298 b.

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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05/24/2011 22:00 9034542257 PABS PAGE 01/01

877-842-7860 8

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED HEALTHCARE METRAHEALTH
PO BOX 30555
SALT LAKE CITY UT 84130

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other
Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO X

b. AUTO ACCIDENT? YES NO X PLACE (State)

c. OTHER ACCIDENT? YES NO X

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
711735

a. INSURED'S DATE OF BIRTH SEX F X

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME
UNITED HEALTHCARE METRAHEALTH

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO X If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 04/30/11
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED

14. DATE OF CURRENT: MM DD YY 05 05 2010 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 05 05 10

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE NICHOLAS TRAN MD

17a.

17b. NPI 1922000710

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE SUPPORTING DOCUMENTS FAXED TO CARRIER

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. V25.12 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 07 10	05 07 10	11		58579		1	6500 00	1		NPI	1326338427
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

Ref # CH45104255671

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN X

26. PATIENT'S ACCOUNT NO. 2978980

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $ 6500.00

29. AMOUNT PAID $ 888

30. BALANCE DUE $ 5592666

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
04/30/11
DATE

32. [illegible]
1919 S SHILOH 333
GARLAND TX 75042
1760660088
a. b.

33. [illegible]
4347 W NW HWY 120 EMB 262
DALLAS TX 75220
1326338427
a. b.

9101114662287